# Camp Shelanu Inclusion Program
# Professional Questionnaire

**For Parents:** A copy of this form is to be given to at least one professional who has met with your child in regard to social, emotional, behavioral or academic needs during the past six months. The professional should return the form to Camp Shelanu directly by January 30.

Child Name _____ DOB _____

Professional Name _____
Professional Address _____
Professional Phone Number _____ Professional Email _____
☐ Physician ☐ Psychologist ☐ Teacher ☐ Occupational Therapist ☐ Other _____

As a legally-authorized parent of the child listed above, I give my authorization for the above named provider to communicate any and all pertinent medical, psychiatric or psychological information with personnel at Camp Shelanu at the Levin JCC. I also give my authorization for Camp Shelanu to contact the provider and discuss information regarding my child as needed.

_____ _____ _____
Parent Name (Printed) Parent Name (Signed) Date

**For Professionals:**
Please complete and return to Camp Shelanu **by January 31** by:

- Mail to: Camp Shelanu, Levin JCC, 1937 W Cornwallis Rd, Durham NC, 27705
- Email to: inclusion@levinjcc.org
- Fax to: 919-354-4960 Attn: Camp Shelanu

**About our program:** Camp Shelanu is an inclusive day camp where campers with a range of physical, social, developmental, sensory, and behavioral disabilities are included with peers in camp groups and activities. Campers who are a good fit enjoy being in group activities and can participate with peers safely without a one-on-one support person. You can read more about our program at https://levinjcc.org/camp-shelanu/special-needs-inclusion/

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Professional's Name: _____ Date: _____

Title: _____ Employer: _____

In what capacity do you see this child? _____

For how long have you known this child? _____

May we contact you, if necessary, for further clarification? ☐ Yes ☐ No

Thank you for your time and consideration!

Child's Name: _____Professional's Name: _____

Please share how this child responds or reacts to the following, or any concerns you have about this child's ability to be successful in an environment with the following. Feel free to attach a separate sheet with more information if needed.

| | |
|---|---|
| Stress and frustration | |
| Changes in routine | |
| Doing non-preferred activities | |
| Large group environment | |
| Frequent transitions | |
| Periods of waiting | |
| Changes to adults and peers | |
| Loud spaces | |

What may trigger this child becoming upset? _____

Describe any instances of hitting, kicking, biting, or other physical aggression towards self or others.
_____
_____

Describe any instances of running away. _____
_____

Are there any cues or coping techniques we should know about to help this child settle down?
_____
_____

Has the child ever required one-on-one supports? ☐ Yes ☐ No ☐ Unknown

Under what circumstances? _____

What kind of accommodations (if any) should be in place? _____
_____
_____

**Camp Shelanu use only:** Date received: _____ Reviewed by:_____

Notes: _____